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Abstract:

Objectives: Informal caregiving relationships play an important role in facilitating recovery outcomes in psychosis. The relationship can serve as a source of positive experiences that co-exist alongside common challenges typically associated with mental health problems. People with psychosis, when compared to the general population, are more likely to perpetrate acts of violence; a relationship that is particularly evident during the first psychosis episode. Though victims of service user violence are typically people already known to them, such as informal carers, there remains a lack of understanding about their caring experiences and needs. The current study sought to address gaps in the literature by exploring the subjective accounts of informal carers supporting a relative experiencing their first episode of psychosis who has also behaved violently towards them.

Design: A cross-sectional design was employed.

Methods: Individual semi-structured interviews, which were audio recorded and later transcribed for analyses, were undertaken with a convenience sample of eight carers drawn from a specialist early psychosis service. Interview questions focused on their experiences of patient violence, the subjective impact and coping strategies. An interpretative phenomenological approach was used to analyse the data.

Results: Participants were mostly living with their relative with psychosis, and were typically female, parents, and from a black and minority ethnic background. Data analyses identified seven key themes from participant interviews including the lack of predictability over when the violence occurred, being scared and fearful, keeping quiet about what happens at home and in the caregiving relationship, and staying safe.

Conclusions: Reports by informal carers about experiencing violence and victimization from their relatives with psychosis is an important issue in some caregiving relationships during the first episode. Developing a more informed understanding of the specific needs of these carers and the caregiving relationship is indicated. The implications for service providers are discussed.

Practitioner points

1. Carers were exposed to a broad range of patient violence, which included being kicked and having weapons used against them. The violence typically occurred within carers' homes, when no other people were around.
2. Patient violence impacted negatively on carer emotional and physical functioning, which included leaving carers living in fear of their own safety and what might become of their relative.
3. The results highlight the importance of routinely asking first episode carers about their experience of patient violence.
4. The development of interventions (e.g. identification of early triggers, de-escalation) that are able to take account of the ongoing nature and complexity of the caregiving relationship but are purposefully aimed at supporting carers to remain safe in their relationship should be explored for their impact.

Introduction

The initial onset of a psychotic disorder can be distressing and traumatic (Bendall et al 2012; McCann 2009) and many individuals experience prolonged periods of untreated illness, including untreated psychosis, before accessing optimal treatments (Addington et al 2004). Depleted social networks and social isolation are common amongst individuals living with psychosis (Killaspy et al 2014; Giacco et al 2016), and are already evident during the initial illness phases (Gayer-Anderson & Morgan, 2013; Sundermann et al 2013). The typical age of first onset means that many young adults experiencing their first episode of psychosis (FEP) will be living with or in close contact with informal carers (Jansen et al 2015). Informal carers tend to be close relatives such as parents and they can make substantial and valuable contributions to patient care and recovery, including improved mortality rates (Revier et al 2015) and reductions in rates of relapse and a need for inpatient care (Norman et al 2005). The caregiving role can also be linked to positive experiences (Bauer et al 2013; Kulhara et al 2012; Onwumere et al 2008), which can include improvements to self-esteem and a greater awareness and clarity of their own strengths and life priorities (Chen & Greenberg, 2005).

Psychosis and violence

Violent behaviour in psychosis often attracts substantial attention in the mental health literature and mainstream media. Considerable efforts have gone into extending our understanding of risk factors and clinical correlates of patient initiated violence (Witt et al 2013; Swanson et al 2006; Bo et al 2011). The current literature identifies a broad range of risk factors for patient violence including younger patient age (Coid et al 2013); substance abuse (Fazel et al 2010); female gender (Swanson et al 2006); male gender (Dean et al 2007); dispositional anger (Nederlof et al.,

2011); untreated psychosis (Large & Nielssen, 2011), treatment non-adherence (Witt et al., 2013) and difficulties in facial emotional recognition (Weiss et al 2006). Similarly, illness symptoms such as delusional beliefs, particularly those about persecution, being spied upon and conspiracy (Coid et al 2013; Onwumere et al., 2016), hallucinations (Swanson et al 2006) and mania (Large & Nielssen 2011; Dean et al 2007) have also been identified.

Though the statistical association between psychosis and patient violence is generally reported as modest (Douglas et al., 2009; Fazel et al., 2009; Coid et al 2006; Taylor, 2008) and most people with psychosis are not violent (Fazel et al 2009); when compared to the general public, people with psychosis are more likely to perpetrate acts of violence, including homicide (Fazel et al., 2009; Short et al., 2013; Nielssen & Large, 2010). This relationship can be particularly evident during early illness phases (Nielssen et al., 2007; Large & Nielssen 2011; Spidel et al., 2010), before initial treatment has commenced (Meehan et al 2006).

A large proportion of FEP patients will access services through the criminal justice system (Anderson et al 2010) and a review of FEP cases in the United Kingdom (UK) found approximately 40% of patients were aggressive at the first service contact and almost half were physically violent (Dean et al 2007). Similar data from a systematic review and meta regression analysis of FEP cases reported that 28% of patients were recorded as being aggressive prior to first service contact and 31% following contact with mental health services (Winsper et al 2013). Reports of patient violence do not necessarily reduce or disappear following first onset and treatment commencement (Steinhert et al 1999; Milton et al 2001). Further, contrary to prevailing myths and misconceptions and in line with other reports of domestic violence, patient initiated violence in psychosis is more frequently directed towards people already known to them

such as family members (rather than strangers) and who may be co resident and female (typically mothers) (Labrum & Solomon, 2015; Fawzi et al; 2013; Belli et al 2010; Nielssen et al., 2007).

Caregiving relationships and patient violence

Carers of people with psychosis experience a significant impact of care (Gupta et al 2015; Sadath et al 2017), which carries considerable implications for their coping efforts, quality of caregiving relationship and illness outcomes (Kuipers et al 2010). Lifetime rates of patient violence towards caregivers has been estimated in some studies at 50-60% (e.g. Kageyama et al 2015; Onwumere et al 2014), and approximately one third of carers report incidents of violence in the preceding year (Kageyama et al 2016; Wing-Yum Chan 2008). Recent data suggests that 40% of FEP patients had been physically abusive towards their parents in the 2 months prior to first presentation (Fawzi et al 2013). However, despite violence featuring in the clinical presentation of many FEP patients (Dean et al 2007) and evidence that informal carers are most likely to be the targets of patient violence (Estroff et al 1998), data are scarce on FEP carers' subjective experience of being exposed to violence from the relative they care for. The limited available literature is almost exclusively based on narratives elicited from carers of longer-term psychosis groups (Kontio et al 2015). Kontio and colleagues, using data from a group interview of eight carers of adults with long-term schizophrenia, found that participants reported experiencing a range of emotional responses after being exposed to patient violence. These included feelings of guilt and fear along with a belief that it was actually part of their caregiving role to be the target of patient aggression and violence (Kontio et al 2015).

The lack of research examining the perspectives of FEP carers exposed to violence from their relative with psychosis prevents a more detailed and informed understanding of their specific

needs and clinical management implications. Moreover, it may help to maintain the secrecy commonly observed with other types of domestic violence. The current study aims to explore the experiences, coping efforts and needs of FEP informal carers who have been subject to acts of violence from the relatives they care for. For the purpose of our study, we defined violence as the experience of being physically harmed.

Methods

Sample

Participants were a sample of convenience and identified from a specialist early intervention in psychosis team. They were identified carers of service users and already known to the team as having been exposed to violence from their relative with psychosis. All participants provided informed consent.

Participants were asked to complete individual semi-structured interviews, facilitated by the first author. The interviews were audiotaped and subsequently transcribed, verbatim, for analysis. The interviewer had no previous relationship or contact with participants outside of the study. The interviews were completed at the university base. The interviews were designed to last approximately 1 hour and participants were given a £10 pound compensation for their time. The interview schedule was reviewed and piloted with a carer consultant. It included questions about their experiences of violence from their relative, the subjective impact, and their coping efforts. After the end of the interview, all participants were debriefed about how they found the interview and offered details on relevant information and support services.

Analyses

The interview transcripts were analysed using Interpretative Phenomenological Analysis (Smith et al., 2010) and undertaken by the first two authors using an idiographic focus. The authors reviewed all transcripts to highlight similarities and differences, note developing themes which were discussed and subsequently organised into subordinate and superordinate themes.

The project was approved by the NHS Trust audit and evaluation committee (ref. PSYAUD15/17).

Results

The sample comprised eight participants of whom seven were female. Participants' mean age was 56.6 years (range 37-72) and seven of the eight self-identified as being from a black and minority background. Most participants were living with their relative with psychosis and just over half of these were male. The mean age of patients was 26.3 years (range 18-30). (Table 1).

Reports of violence

The carer participants all reported that this was the first time in which they had reflected on the violence and its related issues.

Participants described a range of violent incidents that they had been subjected to by their FEP relative. The episodes varied in frequency with some participants reporting experiences on a daily or weekly basis, while for others it could occur on a monthly or less frequent basis. The severity of the episodes were also variable. It included episodes where carers had being hit, kicked, had everyday household items employed as weapons against them and where they had

been subject to threats of being harmed. The violence tended to occur mainly in the carers' own home and when alone with their relative.

Most of the time it will happen when I'm alone with her, when the brother or sister are there it doesn't happen..... but I don't know, it's when she's alone with me. [P4]

She believed that she's not sick and I took her in [to hospital] for them to detain her. So she became really abusive to me, she attacked me, she hit me, and she punched me in the face. [P6]

The physical side is not actually touching, but threatening to do something to you... to myself, which is not a nice situation because you don't know what the outcome is going to be. [P8]

Themes

Seven key themes were identified from the participant interviews (Table 2).

1) It seemed to come out of nowhere/ I know its coming

Participants described being exposed to violence from relatives, which were split between those that appeared to have a sudden onset, without any known or obvious triggers or subtle warnings, and those where it was clear to the carer that something was about to happen.

He didn't show it, didn't show any particular signs that I could really like observe, it could be like we are in one room talking having a nice time. He had like moments where he would be having fun with me and then suddenly he would switch and become little bit annoying, and um demanding as well, and um, it start like sometime innocent stuff tapping on the shoulder and once he started it was like he couldn't stop, or he was saying weird things to me He would be doing like tapping into one particular place and uh, you know after time it become painful in

the same spot all the time so and I was like “oh you’re hurting me” you know and he would like ignore it and smiling and doing you know the same thing, and I was like oh he’s weird you know because, it looks like he’s, you know like have so many or something. [P1]

Though for others there appeared to a gradual shift in their relatives’ presentation and usual behaviours that were indicative that something difficult was about to occur.

I’ve noticed once or twice when she missed the medication she will start complaining but she will always tell me “I don’t um, I’m not feeling fine” you know or things like “you don’t know what I’m going through” she says “you know mum you don’t understand” when she starts telling me those things I know something, it’s really not going on fine. [P2]

2) I think it happened because....

Participants described an ongoing process of trying to make sense of events and achieve a better understanding from their relative about their violence and why they had behaved in that way towards them. The explanations they offered were varied but included factors such as illness (e.g. hearing voices), excitement, anger, difficult upbringing, boredom, drugs and the fault of the carer.

Like the voices will tell him “Tell her to go” and “swear at her”, make him against me, so he would get very angry that I’m there. He explained to the doctor that one side of him, not he himself, my son, he doesn’t want to hurt me, but the voices are telling him to hurt me. So it’s a fight between him and the voices. He goes back to his senses after some time, but first he has to be aggressive, but he explained it wasn’t him. It was the voices telling him what to do and what to say. [P7]

It's like he wouldn't, recognise that he's hurting me, I don't think he's like evil or doing anything you know but it's just that, at that moment, he doesn't recognise that he's hurting you know. [P1]

I just keep questioning, "why did you do it, why did you behave like this, what have I done for you to be so horrible to me when I've done all these nice things to you. I've looked after you, I've cared for you I've been there for you no matter what, I've helped you with so many things which a lot of people probably, lot of mums probably wouldn't do, but I've done everything". I think that's the upsetting thing, it's why take it out on me, why are you so angry at me and I think it's all to do with the past it's not to do with the present it's all to do with what's happened before [i.e. difficult childhood, parental discord]"[P8]

3) The aftermath: it's all forgotten now and I didn't mean it

For some participants, there was a sense that following an incident of violence, their relative typically presented as being full of huge sorrow and regret about their behavior or tended to behave in a manner to suggest their behaviour was a thing of the past or had never happened.

Do you know after he stopped, I used to sit him next to me and I go "why are you doing this to me, you know I love you and you don't need to be like this and we need to talk about things" and, I don't know and then he goes "but I love you mummy as well" and then he give me a nice hug for example, and he say "ah I'm really sorry" and apologise for the incident and "really sorry I don't know what happened to me why I'm like that" you know. [P1]

Every time it [violence] happens she will stop coming to see me and ringing me. And then after a few weeks she will come back..... you know the last episode what happened now she won't come for a few weekends now, she will leave it long before she comes [P4].

4) It does affect me

Participants described the significant impact of their relative's violence on their own functioning. For some, there had been an identified point of feeling that they had reached their emotional and physical limit, and no longer felt able to cope.

I think at some point his behaviour had become a bit overwhelming for me and uh I didn't know, how to, how to deal with it... I think I put on weight from the stress a little bit and um mainly because um I had some operation but I think it affected me in a way that maybe I eat more at night and I sleep long as well. it affect me more in a way that I'm not concentrating on myself very much. [P1]

Its affected me physically, mentally, spiritually; every aspect of it has affected me.. at times, most times, I dunno what to do.... oh I'm getting tired of it now, right now if she calls me telling me she's coming to my house I would say no. I'm not, I haven't recovered yet from the last, the last time, I haven't recovered. I just sometimes, I recover from it, she comes back I'm ready, but right now I'm not ready, if she comes to see me now I would say no I just want peace I don't want to get out of my house to be scared of you, but I know after a few weeks she will call again and I will say yes you can come, she will always call to ask me if she can come. [P2]

Fear: I am scared of and for you

A sub theme related to participants' expressions of fear. Participants described a fear they experienced around their relative's violence. For some it reflected a fear about what their relative might do to others (in addition to themselves) and a fear about what might happen to their relative and where they might end up because of their behaviour (e.g. prison, hospital).

I wasn't really scared for myself I was more scared for him... I didn't want anything to happen and then like um for him to go back to hospital or something worse happen in the street maybe, um you know, like he would attack someone because he had this um, when he just become ill he used to like um attack people in the street so I was worried about him really much.....and then my daughter she was already pregnant then, and um I was worried as well what he's gonna be like when the baby's gonna be born, she doesn't live with us but um we keep close relationship.[P1]

After the last time it happened in the day time in the afternoon, now I don't think I'm, I trust her anymore now no, I wouldn't sleep the night alone with her, if no one is at home. In the daytime I know I can just shut the door and leave her, but in the night time I wouldn't anymore, not if no children is at home..... if I'm lying down on the settee and she look down at me and when she's talking and slowly, I try to get up I don't want her to know I'm scared. ...She's stronger than me you know, she very strong. [P4]

Sometimes I'm scared, depending on the way I see her, how she behaves normally they have levels it depends at what level I see her some can be worse some can be very threatening and frightening, for me, um, at times I'm so scared, at times I'm just, I'm confused I don't know what to do I don't want to move out, I don't want to walk out I don't know where, as if I'm walking on eggshells I don't know what to say. [P2]

5) Keeping safe

As part of their coping efforts in anticipation of an incident occurring or following an incident, participants reflected on a need and importance of physically withdrawing to a safer space and taking precautions or pre-emptive measures to make themselves and their family home safe.

Some described a process of trying to be careful in terms of how they spoke and interacted with their relative, and closely monitoring their relative's responses while others reflected on having relevant items (e.g. keys, travel pass) ready.

It's only once she said "oh I stab you" that was the day I thought I have to be very very careful and make sure I was standing by the door to the kitchen because when, I've never heard her say that so everything was like whoa, I hope she doesn't come to the kitchen and attack me and because I have XXXXXXXX, you can't do anything so I was just at a lossI just try to be as safe as possible, put things away, I have it in the back of my mind she's unstable, anything can happen like if there's an argument between me and her, I make sure everything is away, anything that can cause danger is out of her reach.[P2]

To avoid contacting the police I prefer to quietly, without her noticing, I just leave the house, just take my keys and my handbag and just leave, and when I come back its like nothing ever happened, she just calm. [P3]

I just answer her back nicely but it doesn't stop her but I just try to talk, not to let her know I'm scared, you know, and when I'm talking to her I don't even let her notice I'm taking my coat, my handbag, cos I don't even know where I'm going but I know have my bus pass in my bag, I need a jacket and I just do it like I'm answering her but nicely, so she doesn't even notice when I'm gone I don't even know she noticed I'm gone. [P4]

6) Changing relationship

Mixed perspectives were offered about how the ongoing episodes and threats of violence had impacted the caregiving relationships. Whilst some carers found it important to talk about their

enduring love for their relative and unchanged relationship, despite their aggression, others noted the adverse impact it was having on the quality of their relationship, which for some had included a gradual distancing and separation.

It hasn't affected me in the way that I will say "oh go away I don't want anything to do with you", no, even though I still try to be the same mum and love her the same way even when she's doing that, I'm not happy, but I still, I can't say I don't like her, I still love her the same way, it hasn't changed. [P2]

I think its taking its toll now, it's beginning to take its toll.... I don't want her to come at the moment I don't have that feeling, I don't feel like I'm worried about her anymore... no it's like I don't care anymore, I'm not worried when I go to bed, you know. [P4]

I think it made us understand each other a lot more..... Yeah there's a better understanding of what he really needs, what he wants, but I wish he wouldn't say it through anger and aggression I wish he'd just be like, just a normal conversational... Some people might decide right, even though you're not well, I don't want to talk to you, I'm going to probably leave you for a couple of months because I'm upset or angry-but I don't ever feel that way: I don't feel upset or angry. I just feel like, I do feel a little bit upset, but not angry. [P8]

7) Keep things quiet

There was variability in carers' self-reported needs and the type and amount of help they would welcome to deal with issues of violence in their relationship and its impact on their health. Ideas of support ranged from not needing any to wanting telephone support and home visits from

the clinical team supporting their relative. However, the importance of keeping quiet about events going on at home and avoiding involvement of police agencies featured in most accounts.

I think um since I spoke to the XXXXXX team they automatically link it with the police alert and uh we had a visitor to come home from the police team as well.I prefer not to involve police because I don't think it was that level of aggression, that I have to really do it, I, I still don't really think its aggression but there are perhaps some elements of aggression in it. [P1]

The team before they told me if she gets aggressive don't be scared to call the police that's the only thing I can do, but that's what I've been avoiding, but if I feel like I can't get out I will have to.... it will hurt me to see her going in a police car to the station or to the hospital I'd rather an ambulance for her....I think it would be good if there was someone I could call you know, instead of the police I don't like that, erm, someone in the profession, if I could call, even if they can't come, at least I know I've shared it with someone... someone in the profession who can talk to her cos she's quite intimidating, if anyone come to my house and behaves like that I know she wouldn't in front of them. [P4]

For some, the reported infrequency of the violence underpinned the need to keep quiet and not upset the status quo.

[the violence] it's not something that come on, that's happening all the time, and because of that I'd rather leave it like that and not shake it or stir anything, it's safe there. [P2]

Discussion

The elevated levels of stress related conditions in carers of people with psychosis have been widely documented (Poon et al 2016; Gupta et al 2015), including the higher rates recorded in

FEP carers (Hamaie et al 2016; Addington et al 2003; Sadath et al 2017). FEP carers adjustment to the onset of a psychotic illness will invariably be affected and complicated by experiences of violence and victimization committed by the person they have assumed a caregiving role for. Our findings suggest a range of emotional reactions and behavioural responses are experienced by FEP family carers who have been victims of patient violence and for whom, potentially, interventions to enhance support and minimize risk of harm might be considered (Asen & Fonagy, 2017).

Participants offered several different reasons in explanation of their relative's violent behaviour which exceeded those represented by the illustrative quotes. Thus, in addition to explanations attributing patient violence to illness symptoms and illicit drug use, there were explanations linking patient violence to their experience of boredom and not having something constructive to do with their time or to their difficult childhood and life events. Some explanations (e.g. violence due to illness, difficult early experience) were consistent with those reported by other studies such as Band-Winterstein et al (2016), in their interviews with parents who had been exposed to psychological abuse by their adult children with psychosis. Our findings also offered support to the work of Fawzi et al (2013) who found that childhood trauma was a significant risk factor for parental abuse committed by adolescents with first episode psychosis.

It seems clear that carers are formulating their own reasons for their relative's violent behaviour towards them, which for some can include self-blame. As seen in the wider literature (Hsu & Tu, 2013), the results highlight the complexity of the experience and the narratives offered by carers to account for and make sense of their relative's behaviour. Exploring these explanations in

further detail and to what degree they converge with explanations for domestic violence in the general population would be indicated, and might help to inform future interventions.

The results linking FEP carers' exposure to patient violence to subjective reports of emotional burden and exhaustion, difficulties in the caregiving relationship, and stigma were consistent with existing literature (Kageyama et al 2016; Vaddadi et al 2002; Onwumere et al 2014; Torrey, 2011). Some participants highlighted having reached their coping limit, of not feeling able to take on any more, feeling exhausted and unable to think clearly. These reactions offer further support to previous investigations that suggest carers who have experienced patient violence score more highly on measures of trauma reactions (Loughland et al 2009, Hanzawa et al 2013). The current findings were also consistent with literature confirming the negative impact of patient violence on carers, even when carers are living separately from their relative (Hanzawa et al 2013). Participant reports of living in fear of their FEP relative were in line with reports from carers of patients with a longer-term illness course (Konito et al 2015). The results highlighted a pattern where carers tended to express a greater degree of fear about potential trouble for their relative (i.e. that the relative's violence might lead to police and criminal justice involvement) compared to carers' fear for themselves and their own wellbeing. It was a fear that impacted on their readiness and willingness to disclose to others about what was happening, to seek help from informal and formal sources, and their beliefs about perceived helpfulness of sharing their home situation with others. Thus, despite the risks presented, there was also a need in carers to protect and shield their relative from external agencies. This was consistent with findings from previous literature (e.g. Ferriter & Huband, 2003).

Prioritising the needs of their relative with psychosis whilst potentially ignoring, minimizing or postponing their own concurs with previous literature (Lavis et al 2015). The carer's fear of

their relative coupled with strategies adapted to maintain their safety (e.g. sleeping with bedroom door locked) invariably have a negative impact on the quality of the relationship and day-to-day functioning and illustrated the difficulties inherent in a caregiving relationship taking place in the context of violence (Konito et al 2015).

The current sample were mainly from ethnic minority backgrounds, which is line with the wider literature. As reported earlier, episodes of violence have been associated with several clinical and social-demographic factors that include age and gender. In some studies, these factors have also included being from a black and minority background (Bo et al. 2011; Dean et al 2007; Coid et al 2013). To date, however, the evidence to explain the process via which ethnic background might elevate the risk of violence remains scarce.

The extent to which participant accounts and identified themes were impacted by variations in patient treatment, length and degree of engagement with treatment remain unknown but important areas for consideration in future studies using with larger groups.

Limitations

The main strength of the study is the focus on the subjective experience in FEP carers. However, the study also had limitations. First, the small sample size and homogeneity in participant demography limits the generalizability of findings to broader caregiving samples. Participants were sampled from one individual service and geographical region. Though all participants, with exception of one, were from a BME background, it is unclear whether ethnic differences are observed in carer victims of patient violence. Further work is required to assess to what extent, if any, our findings reflect a particular issue in the experience of psychosis and/or interpersonal environments within BME groups. Further, we note the absence of accounts from siblings. However, we already know that the younger sisters of people living with schizophrenia can

report higher rates of patient violence and a negative caregiving impact (Kageyama et al 2015; Bowman et al 2014). Studies employing larger FEP samples and systematic recording methods are indicated. Second, the extent to which the reports represent an accurate representation of the issues cannot be confirmed. The accounts offered are likely to have been influenced by participant readiness to disclose highly sensitive and personal details. Participants may have represented those with either a more or less extreme experience of patient violence. Third, the current study was solely reliant upon carer participant self-report data. No clinical details were collected on any treatments and interventions that patients were receiving and levels of engagement with treatments, which may have offered further context to the findings. Thus, the extent to which participant accounts and identified themes were impacted by variations in patient treatment remain unknown, but are important areas for consideration in future studies using larger groups. Future studies may be strengthened by also eliciting the narratives of service users and triangulating the data. The integration of data are likely to facilitate the development of evidence based clinical implications. Finally, the study design was cross-sectional, which precluded any discussions about causal pathways. Notwithstanding such limitations, the participant accounts were supported by the broader literature.

Clinical implications

Given the methodology and sample size, we are cautious in our recommendations. However, participant accounts suggest that most violence occurred within the carers' home and when other people were not present. It highlights carer proximity, availability and isolation as potentially modifiable important risk factors (Labrum & Solomon, 2016). Though preliminary, the results underscore the importance of routinely assessing and screening FEP carers for risk of violence in

their caregiving relationship as part of a service admission and/or discharge protocol. The findings could be used first to identify areas of unmet need in the caregiving relationship in terms of violence exposure and carer safety and wellbeing and secondly to formulate individualized care (safety) plans for the carer. The plans would be able to take account of the unique aspects of their caregiving relationship and multiple roles held by carer (e.g. parent, carer, victim) and patient (e.g. adult child, relative with psychosis, perpetrator of violence). Similar to a 'crisis' or relapse prevention' plan, the safety plan would include different sections such as early warning signs for potential violence, contact details for relevant people, organisations and services, including the emergency services. The recent NICE guidance on violence and aggression management in mental health highlights the adverse impact of violence on carers and the importance of working in partnership with carers to identify effective management pathways (NICE, 2015). The importance of employing techniques that have proved effective in the past in de-escalating situations are emphasized along with greater proficiency with the early identification of incipient signs and precipitants of patient violence, and recognition of the importance and use of personal space.

Carer and family based psychological interventions are included as part of recommended treatments in psychosis guidelines (NICE, 2014; Kreyenbuhl et al 2010). In line with a recent trend in modifying interventions to target specific patient presentations in psychosis (e.g Mueser et al 2012; O'Brien et al 2014), the impact of tailoring carer and family intervention to address issues related to violence in caregiving relationships should be explored for their efficacy and ease of implementation in specialized early intervention in psychosis services. The contribution of peer based in interventions to improving the quality of family relationships in mental health

and reducing conflict should also be considered (Mercado et al 2016; Schiffman et al 2015). Services need to be aware that carers are likely to be reluctant to share details about violence related issues in their relationship and this may particularly be the case in situations where the aggression recently commenced following the onset of illness (Hodgins & Klein, 2016).

In line with suggestions (Konito et al 2015), feedback from some participants highlighted a need to be able to contact someone they could trust to talk about their situation but without making the home situation and caregiving relationship worse. Thus, it would be important to explore carer concerns about undertaking any therapeutic and safety promoting work, and to review safeguarding procedures within care plans. Since carers expressed concern about disclosing their home situation and fearful of their disclosure triggering adverse or negative care response for their relative, it might be helpful for clinicians to discuss more openly and routinely with all family carers, the broader issue of family violence and the different type of strategies and approaches that services will have at their disposal to support families experiencing violence.

Conclusion

Informal carers adaption to the first onset of psychosis in a relative is typically a complex and emotional process (Morin & St-Onge, 2015; Lavis et al; 2015). Our preliminary findings suggest that reports of violence and victimization from relatives with psychosis is an important area of concern and an additional issue to manage for a sub group of FEP carers. Given the central and vital role played by FEP carers in improving patient outcomes (Revier et al 2015; Jansen et al 2015), the importance of responding to carer needs and delivering optimal interventions that facilitate their wellbeing deserves prioritisation from service providers and researchers alike.

Further research on FEP carers and patient violence is required to increase awareness amongst carer groups and service providers and support development of helpful interventions.

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